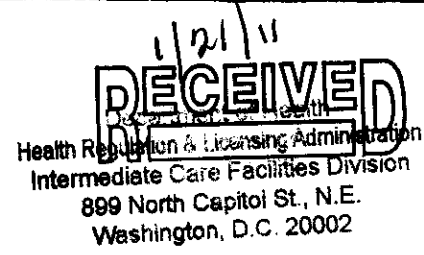


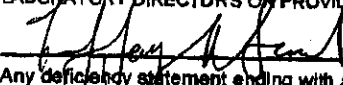
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 01/11/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G167	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/17/2010
NAME OF PROVIDER OR SUPPLIER CARECO 10			STREET ADDRESS, CITY, STATE, ZIP CODE 1613 TAYLOR STREET, NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS A monitoring survey was conducted on 12/17/2010 to assess the condition of the adaptive equipment being utilized by the clients who reside at this facility. All four clients residing in the facility were selected as the survey sample. The findings of the survey were based on observations and interviews in the home, as well as a review of the client and administrative records, including the unusual incident reports.	W 000	<div style="text-align: center;">  </div>		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's qualified mental retardation professional failed to ensure all clients received and were taught to utilize their adaptive equipment to the best of their abilities for three of four clients residing in the facility. The findings include: 1. The facility's QMRP failed to ensure all staff demonstrated competency in providing clients the proper adaptive equipment during meals. [See W194] 2. The facility's QMRP failed to ensure all clients were provided the proper and necessary adaptive equipment as needed and in a timely	W 159	W159 This STANDARD has been met as follows: 1. The QMRP has trained the staff on the Adaptive Equipment of the individuals in the home. The QMRP has been trained on Careco Inc.'s Adaptive Equipment Protocol and Adaptive Equipment Policy. The QMRP is expected to train the staff at least annually and when new adaptive equipment is acquired for individuals in the home. 1/20/11 2. The QMRP has been trained on the timely acquisition of adaptive equipment. The QMRP is expected to obtain adaptive equipment no later than 60 days from when the need has been identified. 1/3/11	1/20/11 1/3/11	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

 Director of Disability Services

1/21/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/11/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G167	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/17/2010
NAME OF PROVIDER OR SUPPLIER CARECO 10			STREET ADDRESS, CITY, STATE, ZIP CODE 1613 TAYLOR STREET, NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 159	Continued From page 1 manner. [See W430]	W 159			
W 194	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff were aware of the adaptive equipments needs of its clients for one of four clients residing in the facility. The findings include: Observation on 12/17/2010, at approximately 12:40 p.m. revealed Client #4 lunch was placed on a raised triangular suction plate and he ate his meal with a built up spoon. Record review on the same day at approximately 12:55 p.m. revealed Client #4's 4/10/2010 mealtime feeding protocol specified his meals should be served on a high sided divided plate. In addition, this client's physical therapy (PT) assessment dated 3/29/2010 further recommended that he be provided a coated spoon to protect his teeth. Interview with the facility's Residential Director (RD) on the same day at approximately 1:10 p.m. confirmed Client #4 should have been provided a high sided divided plate as listed on the Mealtime Feeding Protocol (MFP) and also should have received a coated spoon to eat his meal. The RD also confirmed that the high sided plate and the	W 194	W194 This STANDARD has been met as follows: Client #4 has received his high sided divided plate and coated spoon. The RD and the QMRP for the home were trained on Adaptive Equipment. The QMRP for the home will ensure that adaptive equipment is acquired for the individuals in a timely fashion. 1/14/11	1/14/11	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/11/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G167	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/17/2010
NAME OF PROVIDER OR SUPPLIER CARECO 10			STREET ADDRESS, CITY, STATE, ZIP CODE 1613 TAYLOR STREET, NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 194	Continued From page 2 coated spoon was not available for him to use at the time of the inspection. She stated she would meet with the qualified mental retardation (QMRP) to review Client #4's records to ensure he received the correct adaptive equipment during meals. The facility's staff failed to demonstrate competency on knowing the type of adaptive equipment Client #4 should receive during meals.	W 194			
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure all clients were provided with the proper and necessary adaptive equipment for three of four residents residing in the facility. The findings include: 1. Interview with the facility's Residential Director (RD) and a review of Client #1's records on 12/17/2010 at 11:10 a.m. revealed the following recommendations: a. Occupational Therapy assessment dated 10/10/2010 recommended he be provided a wheelchair for safe community outings.	W 436	W436 I.a-c A 719A form was submitted to NRH for Client #1 wheelchair for community outings. Careco's maintenance department is in the process of obtaining and installing hand rails as recommended by the PT. Client #1 has a clothing protector and it was available in the home at the time of the survey. Staff is trained on the use of adaptive equipment for Client #1. The QMRP has been trained on the timely acquisition of adaptive equipment. 1/20/11	1/20/11	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/11/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G187	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/17/2010
NAME OF PROVIDER OR SUPPLIER CARECO 10			STREET ADDRESS, CITY, STATE, ZIP CODE 1613 TAYLOR STREET, NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 436	<p>Continued From page 3</p> <p>b. Physical Therapy assessment dated 8/10/2010 recommended that he be provided a custom molded wheelchair, handrails on each side of the hallway and handrails around the patio towards the right [leading] up to the rear door.</p> <p>c. Mealtime Feeding Protocol dated 4/10/2010 recommended a clothing protector (bib) and a high sided divided plate.</p> <p>None of the items presented above were available or in place at the time of the monitoring visit. Interview with the facility's RD on the same day at approximately 11:30 a.m. revealed she would meet with the qualified mental retardation professional (QMRP) and work to implement these recommendations.</p> <p>The facility failed to ensure this client was provided all the adaptive equipment identified by his individual service plans.</p> <p>2. Interview with the facility's Residential Director (RD) on 12/17/2010 at 11:45 a.m. revealed she was informed that Client #3 required the use of a non-skid mat and a raised toilet seat.</p> <p>Review of Client #3's records on 12/17/2010 at 11:40 a.m. revealed his 1/19/2010 Physical Therapy Assessment recommended a shoe insert to address his leg length discrepancy (left leg).</p> <p>On 12/17/2010, Client #3 arrived home at approximately 3:30 p.m. from his day program and the RD checked his shoes and found that he was not using the insert. Further interview with the facility's RD on the same day at approximately 3:40 p.m. revealed she would meet</p>	W 436	<p>2. The Physical Therapist has discontinued the use of the shoe insert for Client #3. But instead has recommended orthopedic shoes, upon follow-up with the orthopedist, it was determined that Client#3 was not a candidate for orthopedic shoes.</p> <p>1/14/11</p>	1/14/11	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/11/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G167	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/17/2010
NAME OF PROVIDER OR SUPPLIER CARECO 10			STREET ADDRESS, CITY, STATE, ZIP CODE 1613 TAYLOR STREET, NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 436	<p>Continued From page 4</p> <p>with the qualified mental retardation professional (QMRP) to address why Client #3 was not using his shoe insert.</p> <p>The facility failed to ensure this client was provided and utilized all the adaptive equipment identified by his individual service plans.</p> <p>3. Interview with the facility's Residential Director (RD) and review of Client #4's records on 12/17/2010 at 12:15 p.m. revealed the following recommendations:</p> <p>a. Physician Order Sheets dated 11/12/2010 prescribed a high low plate, plastic coated spoon, and an electric toothbrush.</p> <p>b. Physical Therapy dated 3/29/2010 recommended that he be provided a coated spoon to protect his teeth when eating.</p> <p>On 12/17/2010 at approximately 12:44 p.m., Client #4 was observed eating lunch. He was not provided a plastic coated spoon or his recommended high/low plate. At approximately 2:50 p.m., the RD attempted to find Client #4's electric toothbrush, but was not able to produce it. She then indicated a new one would have to be purchased. The RD agreed to meet with the qualified mental retardation professional (QMRP) to ensure that Client #4 receives the recommended adaptive equipment.</p> <p>The facility failed to ensure this client was provided all the adaptive equipment identified by his individual service plans.</p>	W 436	<p>3. Client #4 has received a high low plate, plastic coated spoon and electric toothbrush. The QMRP has been trained on the timely acquisition of adaptive equipment.</p>	5/14/11	

PRINTED: 01/11/2011
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/17/2010
NAME OF PROVIDER OR SUPPLIER CARECO 10			STREET ADDRESS, CITY, STATE, ZIP CODE 1613 TAYLOR STREET, NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
1 000	INITIAL COMMENTS A monitoring survey was conducted on 12/17/2010 to assess the condition of the adaptive equipment being utilized by the clients who reside at this facility. All four clients residing in the facility were selected as the survey sample. The findings of the survey were based on observations and interviews in the home, as well as a review of the client and administrative records, including the unusual incident reports.	1 000			
1 183	3508.4 ADMINISTRATIVE SUPPORT Each GHMRP shall have a Residence Director who meets the requirements of § 3509.1 and who shall manage the GHMRP in accordance with approved policies and this chapter. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility's qualified mental retardation professional failed to ensure all clients received and were taught to utilize their adaptive equipment to the best of their abilities for three of four residents residing in the facility. [Residents #1, #3 and #4] The findings include: 1. The facility's QMRP failed to ensure all staff demonstrated competency in providing the proper adaptive equipment during meals. [See Federal Deficiency Citation W194] 2. The facility's QMRP failed to ensure all clients were provided the proper and necessary adaptive equipment as needed and in a timely	1 183	1183 This statute has been met as follows: 1. The QMRP for the home has trained the staff on the adaptive equipment needs of the individuals at meals. The QMRP is expected to train the staff at least annually and when new adaptive equipment is acquired for individuals in the home. 2. The QMRP has been trained on Careco Inc.'s Adaptive Equipment Protocol, DDS and Careco's Adaptive Equipment Policy. The QMRP for the home will ensure that adaptive equipment is acquired for the individuals in a timely fashion.	1/20/11 1/5/11	

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

Director of Disability Services

(X6) DATE

1/21/11

0000

ZINK11

if continuation sheet 1 of 2

PRINTED: 01/11/2011
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/17/2010
NAME OF PROVIDER OR SUPPLIER CARECO 10			STREET ADDRESS, CITY, STATE, ZIP CODE 1813 TAYLOR STREET, NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
I 183	Continued From page 1 manner. [See Federal Deficiency Citation W436]	I 183			

Health Regulation Administration
STATE FORM

6590

ZINK11

If continuation sheet 2 of 2